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Z 000	COMMENTS IRI of 9/7/15 - IL79914 COMPLAINT #1524964/IL80018 Statement of Licensure Violations	Z 000		
Z9999	FINDINGS 350.620a) 350.1060e) 350.1210 350.3240a) 350.3240b) 350.3240e) Section 350.620 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility which shall be formulated with the involvement of the administrator. The policies shall be available to the staff, residents and the public. These written policies shall be followed in operating the facility and shall be reviewed at least annually. Section 350.1060 Training and Habilitation Services e) An appropriate, effective and individualized program that manages residents' behaviors shall be developed and implemented for residents with aggressive or self-abusive behavior. Adequate, properly trained and supervised staff shall be available to administer these programs. Section 350.1210 Health Services The facility shall provide all services necessary to maintain each resident in good physical health. These services include, but are not limited to, the	Z9999	Attachment A Statement of Licensure Violations	

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Z9999	Continued From page 1 following: Section 350.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator e) Employee as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that an employee of a long-term care facility is the perpetrator of the abuse, that employee shall immediately be barred from any further contact with residents of the facility, pending the outcome of any further investigation, prosecution or disciplinary action against the employee. These requirements were not met as evidenced by: Based on record review and interview the governing body of the facility failed to ensure their own policies to prevent abuse and neglect were implemented affecting 1 of 1 (R1) individual who reported he intentionally fell from a bridge overpass onto the interstate after he reported ongoing verbal and psychological abuse by staff when the facility failed to: > Ensure R1 was free from verbal/psychological abuse while a resident of the facility > Implement facility policies to ensure residents were free from verbal/psychological abuse after it was reported > Ensure sufficient safeguards were implemented for R1 after an employee witnessed R1 on the bridge immediately prior to his intentional fall	Z9999		

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Z9999	Continued From page 2 > Provide sufficient supervision and implementation of R1's Behavior Management Plan addressing his diagnosis of Bipolar Disorder and Depression > Ensure R1 was receiving the appropriate antipsychotic medications as ordered by his psychiatrist > Ensure a complete and thorough investigation was conducted > E3, Direct Care Personnel (DSP) notified E2, Resident Services Director (RSD) of R1's report of verbal/psychological abuse and E2 failed to act upon the complaint per facility policy. > The facility failed to conduct a thorough investigation when they failed to interview E3, E7 and E10(DSP) during their investigation process Findings include: In review of R1's Individual Service Plan (ISP) dated 1/21/15, R1 is a 20 year old male with diagnoses which include Mild Intellectual Disability, Bipolar, and Attention Deficit Hyperactivity Disorder. R1's ISP also has documented that he "has had some depression". R1 has the following documented in his ISP under Safety: "(R1) needs assistant (sic) by staff while in the community". It also is documented "(R1) is able to walk and ride his bike around the neighborhood." R1's Behavior Management Plan (BMP) dated 2/21/14 has the following documentation: "(R1) has a secondary diagnosis of Bipolar, Behavioral, and ADHD. (R1) displays maladaptive behaviors	Z9999		

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in the form of somatic complaints which may include making statements regarding phantom illnesses and/or injuries and in the form of depressed mood which may include withdrawal from others, crying and statements of or appearing to be sad."

A facility policy titled Abuse and Neglect Program dated April 10, 2014 defines abuse as, "The willfull infliction of injury, unreasonable confinement, intimidation punishment with resulting physical harm, pain or mental anguish.

The definition of mental abuse per this policy is, "humiliation, harassment, threats of punishment or deprivation."

The definition of verbal abuse per this policy is, "the use of oral, written or gestured language that willfully includes disparaging or derogatory terms to residents...".

1) A "Facility Investigation - Resident Injury, Inappropriate Verbal Interaction" report dated 9/7/15-9/11/15 states in summary: "On 9/7/15 at approximately 4:00pm (R1) was taken to (a local trauma center) for injuries sustained after a fall from the overpass on Springfield Road onto Illinois Route 474 (an interstate). The initial emergency report noted a chance fracture of (R1's) vertebrae and a laceration to the back of (R1's) head requiring 12 staples."

The report further stated, " (R1) stated the fall was intentional, and that he felt "worthless". (R1) made an allegation of verbal abuse stating (E4) called him worthless..."

An "Out of Hospital Care Report" dated 9/7/15 and dispatched at 15:12:01 has the following

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findings: Found patient conscious, alert, but unable to answer questions laying on (the interstate roadway) 474 eastbound. Witnesses state patient jumped from an overpass landing on his feet (approximately 25 feet). Patient had a documented laceration to the back of his head and an obvious spinal deformity of the thoracic vertebrae.

Z1, eye witness who was with R1 on the bridge when he fell over was interviewed on 9/11/15 at 11am and stated the following: About 3pm on 9/7/15, Z1's daughter, (Z2) seen R1 sitting on the bridge and thought he looked distressed, she turned her car around and crossed the bridge again before returning home to get Z1. Z1 called 911 when Z2 informed her what she saw.

Z1 and Z2 returned to R1 where he still sat on the railing near the center of the bridge with his back to the the interstate below. Z1 tried to talk to R1, offering him soda and cigarettes if he came down from the railing. Z1 asked R1 if he was okay at which time R1 said yes and shook his head no. R1 then said, "No, I'm sorry", put his arms and head back and went over the bridge backward. Z1 called 911 again.

R1 was interviewed on 9/10/15 at 4:45pm. R1 was asked about the incident on 9/7/15. R1 stated that he intentionally fell backward off of a bridge overpass (onto the interstate). R1 was asked why he did this. R1 stated, "I did that because I felt no one cared about me at my house."

R1 was asked why he felt this way. R1 stated E4 kept telling him that he "couldn't read, couldn't pay bills and would go to jail if he left the house."

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R1 stated, "I feel pathetic."

R1 was asked what he thought would happen when he jumped from the bridge. R1 stated, "I thought I would die. I closed my eyes and went over backward and my life flashed before my eyes."

R2 was interviewed on 9/15/15 at 12:45pm and asked if she had ever heard anyone in the facility say mean things to any resident who lived there. R2 stated E4 had told R1 that he, "can't read, can't spell and is worthless".

R2 was asked what R1's reaction was to what E4 said to him. R2 stated R1 seemed "really mad and sad".

R2 was asked when this occurred. R2 stated about 1-2 weeks ago.

The Facility Investigation had an interview with R2 on 9/7/15 which has the following documented, "I heard (E4) call (R1) worthless".

R3's written statement signed 9/7/15 has the question, "Have you heard any staff member call a resident worthless?" R3's answer is as follows, "I don't know - (E4) told (R1) that he couldn't read." R3 was then asked when this occurred. R3's documented response was, "I don't know it was a while ago. It was the other day."

The Facility Investigation Findings/Recommendations signed by E1 read, "The allegation of inappropriate verbal interaction between (E4) and (R1) was substantiated based on witness statements.

2) During R1's interview on 9/10/15 at 4:45pm,

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R1 was asked why he jumped from the bridge. R1 stated, "I did that because I felt no one cared about me at my house."

R1 was asked why he felt this way. R1 stated E4 kept telling him that he "couldn't read, couldn't pay bills and would go to jail if he left the house."

R1 stated, "I feel pathetic."

R1 was asked if he told anyone that E4 had said those things to him. R1 stated he had told E3 and E8, both DSP's.

R2 was interviewed on 9/15/15 at 12:45pm. R2 stated E4 had told R1 that he, "can't read, can't spell and is worthless".

R2 was asked when this occurred. R2 stated about 1-2 weeks ago.

R2 was asked if she reported E4 was saying these things to R1. R2 stated she had told E8, but E8 didn't care. R2 stated "They don't help us. They don't want to hear it and tell us to just deal with it."

E8 was interviewed on 9/16/15 at 2:21pm and asked if it had been reported to her that E4 talked in a derogatory manner to R1. E8 denied knowledge of this.

E3 was interviewed on 9/15/15 at 12pm and asked if she had knowledge of E4 treating R1 inappropriately. E3 stated, yes, R1 had told her that E4 talked negatively to him and treats him very poor.

E3 stated R1 told her E8 had witnessed E4 calling him "ignorant, stating he could not read

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Z9999	Continued From page 7 and he would go to jail if he leaves the residence." E3 was asked if she reported the allegation per the facility policy. E3 provided a text message she sent to E2 on 8/29/15 at 5:57pm which read in summary, Just for your information, (R1) needs to talk to you as soon as possible. (E4) made a very hurtful comment to him and it is affecting him very negatively. I'm trying to let him know not to let what she said bother him but what was said was unnecessary. E2, RSD, was interviewed on 9/16/15 at 10:45am and asked if she was notified by staff that E4 was talking to residents in a derogatory manner. E2 stated no. E2 was asked if she received a text on 8/29/15 at 5:57pm from a staff member regarding E4 making negative comments to R1. E2 stated, "I can't remember, it (the text) could very possibly have been there." E2 further stated that one staff member doesn't get along with another staff member so if E3 text her, she may have just taken it as a conflict between staff. E2 was asked what the facility policy is if she is aware of an allegation of any type of abuse. E2 stated, "I should report to my administrator." E2 then stated, "I did receive the allegations (of abuse)." E2 was asked who she received the allegations from. E2 stated, "I cannot remember." E2 was asked if she reported E3's report of an	Z9999		

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allegation by R1 that E4 had been verbally abusive to him to her administrator. E2 stated, "I'm gonna say no."

E2 was asked what she did after she received the allegations that E4 was verbally/psychologically abusing R1. E2 stated, "I asked (E4) about it, but she denied doing it."

At 12:36pm on 9/16/15, E2 called back to clarify her answers to this surveyor.

E2 stated, "I looked at that text (from E3) about (R1) and (E4). I did receive that text."

E2 was asked, did you act upon that per your facility policy. E2 stated, "Not specifically, (E1, Administrator) and I talked about it."

E2 further asked how this surveyor was able to obtain the information from E3 as this employee was not interviewed during the investigation.

3) A Facility Investigation - Resident Injury Report dated 9/7/15-9/11/15 has an interview with E6, DSP, documented as follows: "9/7/15 - I saw (R1) standing on the overpass about 2:15pm I stopped and told (R1) to come back to the building."

The interview further reads, "9/8/15 - I observed (R1) standing on the bridge on the sidewalk. I pulled over and asked him what he was doing. He said, 'I'm looking at,' then he pointed to the side of 474 (interstate roadway)."

The Report asks E6 why she did not provide this information to the RSD when she spoke to her at 2:30 (about another issue). E6 responded, "I thought he just rode out to (sic) far. I thought he was exercising."

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A section of this report titled "Findings/Recommendations" has documentation as follows: "Through the course of the investigation (E6) stated that she witnessed (R1) on the bridge at approximately 2:10pm." It further is documented, "On 9/8/15 (E6) was asked; did you put any precautions in place or take any action for resident safety? (E6) confirmed that she did not."

A handwritten statement from E6 as interviewed by E2 and dated 9/7/15 at 6:12pm has the following documentation: "2:30pm Staff states that when approaching house for second shift she saw (R1) standing on overpass, staff states she stopped. States (R1) was pacing - walking in circles with hands on hips. Staff asked 'What are you doing'. Staff states (R1) said he was looking at something and pointed out to the left side of highway. Staff then asked (R1) to get his bike and come back to the house."

The Facility Investigation also has documented after R1 returned to the house after E6 found him on the bridge, he then asked staff to leave the facility at approximately 3:15 to ride his bike...A witness observed (R1) on the bridge on Springfield Road over Illinois Route 474. The witness observed (R1) jump from the bridge onto Illinois Route 474."

E1, Administrator, was inteverviewed on 9/15/15 at 10:30am and was asked if E6 was aware R1 had been on the bridge prior to his intended fall. E1 stated yes E6 reported she seen him, asked him to come home and told other employees. E1 stated it was later clarified that E6 did not tell other employees nor put safety precautions in place for R1. R1 was allowed to leave on his bike

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again shortly after at which time he intentionally fell backward off the bridge with witnesses.

4) R1's Behavior Management Plan (BMP) has the Method to Treat R1's Depressed Mood as follows:

- Staff will approach R1 in a calm manner and ask if he is okay

- Staff will listen to R1's concerns and assure him that they will attempt to resolve any concerns he has. R1 will receive praise if he responds positively.

- If the behavior continues, staff will encourage R1 to participate in activities that he enjoys such as computer games, bike riding or making phone calls.

During a review of records, a Facility Investigation - Resident Injury, Inappropriate Verbal Interaction dated 9/7/15 - 9/11/15 has an interview with E4 (DSP) dated 9/7/15 which has documented, "When I arrived this morning at work (R1) came to me and said he was sad. I asked him why he was sad (R1) stated that he couldn't have contact with (his girlfriend) per her mother."

In a written interview with E5, DSP, dated 9/7/15 , E5 was asked if anyone had told her they were sad. E5's written response reads, "Yes yesterday."

The next question reads, "If yes then who?" The response is documented, "(R1). He said he was sad because (his girlfriend's) mom called and said they couldn't talk anymore."

A handwritten interview written by E2 (RSD) while

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interviewing E6 (DSP/Cook) on 9/7/15 at 6:12 pm is documented as follows: "Told cook he couldn't have contact with girlfriend per girlfriend's mother. Found (R1) in garage thirty minutes later - he was standing in the doorway looking around - when staff asked what (R1) was doing he said just looking around. Staff walked (R1) back into house after locking garage."

The interview has further documentation: "Staff (cook) then talked to (R1's) girlfriend on phone- girlfriend called the house - staff states girlfriend asked if staff knew about no contact per her mom. Staff acknowledged then hung up."

During an interview with R1 on 9/10/15 at 4:45pm, R1 was asked why he intentionally fell from the bridge. R1 stated, "Because I felt no one cared about me at my house." R1 was asked why he felt this way and responded E4 made derogatory comments. R1 stated, "I feel pathetic."

R1 was asked if he had recently had contact with his girlfriend. R1 stated his girlfriend's mom said they couldn't see each other any more. R1 was asked if he told anyone how he felt about that. R1 stated on Monday 9/7/15 he told E4 he felt sad and was upset because he could no longer see his girlfriend. R1 stated E4 said, "I don't want to hear it, go to your room if you're going to cry."

There was no documentation provided regarding R1's behavior prior to his intentional fall from the bridge. There is no documentation of R1's behavior program being implemented after staff had knowledge of his recent breakup with his girlfriend.

5) R1's Medication Administration Record (MAR) for 9/01/15 through 9/30/15 has the following

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antipsychotic and antidepressant medications listed: Abilify 15 milligrams once daily, Prozac 20 milligrams once daily, Depakote ER 500 milligrams three times daily, Lamictal 100 milligrams one tablet at bedtime. Staff had initialed indicating administration of these medications 9/1/15 through 7am on 9/7/15 (Lamactil was last given at 8pm on 9/6/15).

A "Psychiatric Progress Note" with encounter date of 8/20/15 has documentation as follows: "Chief Complaint: Patient presents with Follow up, Bipolar."

The History section of this note has the following documented, "When pt (patient) comes in to see me shows no signs of confusion but not sure about his medications."

A section titled "Assessment" has the following documented, "Doing well with current regimen. Continue Seroquel 400 mg (milligrams) hs (hour of sleep), Lamictal 100 mg hs, Divalproex (Depakote) 500 mg TID (three times daily."

An "After Visit Summary" dated 8/20/15 from the Psychiatric visit has a section titled Medications and states, "If you believe this list is not correct, please call the office."

The Outpatient antidepressant or antipsychotic medications listed are as follows: Divalproex (Depakote) 500mg three times daily, Lamotrigine (Lamactil) 100mg nightly, and Seroquel 400mg daily at bedtime.

This After Visit Summary is acknowledged and signed by E9, RN Nurse Trainer on 9/8/15.

E1, Administrator, was asked during interview on

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Z9999	Continued From page 13	Z9999		

9/15/15 at 10:30am if R1 was placed on antipsychotic medications per the physician visit notes on 8/20/15 or if his outpatient medications were clarified regarding the discrepancy. E1 stated no.

E1 was asked if the medications listed to continue on the psychiatric report of 8/20/15 were consistent with the medications R1 was currently receiving. E1 stated no.

6) A Facility Investigation - Resident Injury, inappropriate verbal interaction report dated 9/7/15-9/11/15 has interviews documented from all residents in the house. This investigation also has interviews from employees.

According to an undated Staff scheduled provided at the beginning of the survey, E3, E7 and E10 all worked with R1 within 24 hours prior to his intentional jump from the bridge.

This facility investigation does not include interviews from E3, E7 or E10 the handwritten documentation or in the summary.

E3 was interviewed on 9/15/15 by this surveyor at 12pm and asked if she had knowledge of E4 treating R1 inappropriately. E3 stated R1 had told her that E4 talked negatively to him and treats him very poor.

E3 stated R1 told her E8 had witnessed E4 calling him "ignorant, stating he could not read and he would go to jail if he leaves the residence."

E3 provided a text message she sent to E2 on 8/29/15 at 5:57pm asking her to talk with R1 regarding negative comments made by E4.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6013320	A. BUILDING: _____ B. WING _____	C 09/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARBROOK PLACE	228 BRIARBROOK DRIVE EAST PEORIA, IL 61611

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Z9999	Continued From page 14	Z9999		

E2, RSD, was interviewed on 9/16/15 at 10:45am and asked if she was notified by staff that E4 was talking to residents in a derogatory manner. E2 stated no.

E2 was asked if she received a text on 8/29/15 at 5:57pm from a staff member regarding E4 making negative comments to R1. E2 stated, "I can't remember, it (the text) could very possibly have been there."

E2 then stated, "I did receive the allegations (of abuse)." E2 was asked who she received the allegations from. E2 stated, "I cannot remember."

E2 was asked what she did after she received the allegations that E4 was verbally/psychologically abusing R1. E2 stated, "I asked (E4) about it, but she denied doing it."

At 12:36pm on 9/16/15, E2 called back to clarify her answers to this surveyor.

E2 stated, "I looked at that text (from E3) about (R1) and (E4). I did receive that text.

E2 was asked, did you act upon that per your facility policy. E2 stated, "Not specifically, (E1, Administrator) and I talked about it."

E2 further asked how this surveyor was able to obtain the information from E3 as this employee was not interviewed during the investigation.

There were no evidence of interviews of E7 or E10 in the Facility Investigation.

(A)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6013320	A. BUILDING: _____ B. WING _____	C 09/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARBROOK PLACE	228 BRIARBROOK DRIVE EAST PEORIA, IL 61611

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IMPOSED PLAN OF CORRECTION

NAME OF FACILITY: Briarbrook Place-14G293

DATE AND TYPE OF SURVEY: 9/24/15, IRI of 9/7/15/IL79914 & Complaint #1524964/IL80018

350.620a)
350.1060e)
350.1210)

Section 350.620 Resident Care Policies

a) The facility shall have written policies and procedures governing all services provided by the facility which shall be formulated with the involvement of the administrator. The policies shall be available to the staff, residents and the public. These written policies shall be followed in operating the facility and shall be reviewed at least annually.

Section 350.1060 Training and Habilitation Services

e) An appropriate, effective and individualized program that manages residents' behaviors shall be developed and implemented for residents with aggressive or self-abusive behavior. Adequate, properly trained and supervised staff shall be available to administer these programs.

Section 350.1210 Health Services

The facility shall provide all services necessary to maintain each resident in good physical health. These services include, but are not limited to, the following:

This will be accomplished by:

I. The facility will review policy and procedures on individual behavioral plans and make available to staff, residents and public.

II. All staff will be in-serviced on how to access, modify and implement individual behavior plans. The in-services will include all staff and will cover, at a minimum, assessment of residents who are at risk of self-abusive behavior, having the properly trained and supervision available and the process for documenting and reporting abuse and neglect to all required sources.

III. Documentation of in-service training, assessments and related follow up actions will be maintained by the facility.

IV. The Administrator, the Director of Nurses will monitor Items I through III to ensure compliance with this Imposed Plan of Correction.

Completion Date: Seven days from receipt of the Imposed Plan of Corrections.

Attachment B
Imposed Plan of Correction

IMPOSED PLAN OF CORRECTION

NAME OF FACILITY: Briarbrook Place-14G293

DATE AND TYPE OF SURVEY: 9/24/15, IRI of 9/7/15/IL79914 & Complaint #1524964/IL80018

350.3240a)
350.3240b)
350.3240e)

Section 350.3240 Abuse and Neglect

a) *An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident*

b) *A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator*

e) *Employee as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that an employee of a long-term care facility is the perpetrator of the abuse, that employee shall immediately be barred from any further contact with residents of the facility, pending the outcome of any further investigation, prosecution or disciplinary action against the employee.*

This will be accomplished by:

V. The facility will conduct an investigation of the incident and take appropriate actions. All abuse allegations be thoroughly investigated and reported to the appropriate authorities.

VI. All staff will be inserviced on how to identify and report allegations or suspicions of abuse or violations of resident rights. The inservices will include all staff and will cover, at a minimum, assessment of residents who are at risk of being abused, how to address resident and family complaints of abuse or neglect, and the process for reporting abuse and neglect to all required sources. The facility administrator will be inserviced on the process for immediately reporting abuse or neglect of a resident by telephone and in writing to the resident's representative, reporting the matter to the department, reporting the matter to local law enforcement authorities, and how to investigate allegations of abuse.

VII. Documentation of inservice training, assessments and related follow up actions will be maintained by the facility.

VIII. The Administrator, the Director of Nurses will monitor Items I through III to ensure compliance with this Imposed Plan of Correction.

Completion Date: Seven days from receipt of the Imposed Plan of Corrections.

JB/Briarbrook Place/11/23/2015

Attachment B
Imposed Plan of Correction